

Contemporary Directions in Theories and Psychotherapeutic Strategies in Treatment of Personality Disorders: Relation to Level of Personality Functioning

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Abstract In this commentary on treatment strategies for personality disorders, we analyze each of the cases and the problem of low motivation in terms of how they fit with the Level of Personality Functioning scale. We then show how patients vary in terms of both level and breadth of pathology. Three of the articles describe patients who are severely impaired and strategies suggested are understood in terms of working with differentiation. The additional three articles present cases where patients have a higher level of personality functioning, and strategies are seen as interventions aimed at integration and improved adaptation. Based on this finding, we argue that the Level of Personality Functioning could be a useful assessment method for improving treatment selection. Finally, we raise questions and offer considerations regarding the understanding of empathy, low motivation and autobiographical memory in the cases presented.

Keywords Personality disorders · Psychotherapy · Mentalization

We would like to thank the editors for this opportunity to express our reflections about the psychotherapeutic strategies in treatment of personality disorders as suggested by the six highly skilled therapists in this special edition. While reading the six presentations, the richness of clinical ideas and theoretical nuance reminded us of Donald

Kiesler's seminal "myths" paper, in which he so eloquently addressed the uniformity myth of much psychotherapy research (Kiesler 1966). The position of Kiesler and kindred spirits is that patients are different and even within the same diagnostic groups, both research on etiology and successful treatment needs to take this into account. How can models of personality pathology be helpful in capturing these individual differences in patients and make a significant contribution to clinician's everyday work? This, of course, is a question of clinical utility. The scientific discussion of clinical utility of personality diagnoses has gained new momentum with the introduction "Working with Differentiation and Integration" section in DSM-5 (American Psychiatric Association 2013). In a recent paper, Hopwood et al. (2013) made a case for connecting the Level of Personality Functioning (LPF) scale with the interpersonal model and links to intervention hypotheses. Furthermore, Hopwood et al. (2013) suggested that in order for "Working with Differentiation and Integration" section models to "migrate" to the official "Case Analyses of Personality Functioning" section the most persuasive argument just might be evidence of superior clinical utility. We believe that the six papers presented in this issue offer a great opportunity to put the LPF scale to the test on this matter. Three presentations on narcissistic personality disorder each offering different perspectives on both pathological processes and treatment strategy testifies to the wisdom of Kiesler's original proposal but also offers an opportunity to test whether the LPF model is better able to capture individual differences than a categorical diagnosis. In a broader sense, it is also interesting to get a sense of how the LPF scale is connected to the fairly detailed descriptions of pathological processes seen amongst patients with quite different kinds of personality disorders such as narcissistic, avoidant and borderline. And finally

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and perhaps most importantly, because the authors provide so many and so specific examples of therapeutic strategies, the cases offer an opportunity to discuss whether or not these interventions are meaningfully linked to the LPF scale; in which case, it would have a potential for exceeding “[Working with Differentiation and Integration](#)” section in regards to clinical utility.

Firstly, our commentary will focus on how the cases presented fit with the LPF scale. Secondly, we will discuss some of the ways these strategies and principles can be understood as methods for working with differentiation and integration in treatment of personality pathology. Finally, we will share some thoughts and questions that came to mind while reading these excellent papers in this special edition of the Journal of Contemporary Psychotherapy.

Level of Personality Functioning (LPF)

The LPF scale has found its place in the DSM-5. Now it is important that clinical interviews are developed and the work of finding its clinical utility is progressing (Bender 2013). The LPF scale offers a new framework for personality diagnosis but holds the promise of an old clinical idea—to expose the patient uniformity myth. Although more evidence is almost always “urgently” needed, today there is a large evidence base that suggests that personality pathology can be treated with some effect with psychotherapy. The evidence is fairly consistent in pointing out that many types and levels of treatment can be helpful for personality pathology (Bateman 2012; Dimaggio et al. 2013). But which patients require a more specialized treatment? And which patients can be helped by many types of treatments and strategies? The DSM-5 LPF scale may or may not be a useful tool for this type of treatment differentiation. It could be that it is the general level (0–4) that is informative but it may also be more specific areas of personality functioning such as identity or empathy that are important in thinking about more specific treatment strategies for different patients. Based on either the case description or the clinical problem some cases displayed (drop-out and low motivation), we have tried to map each of the presented treatments to the level of personality functioning we believe they fit (see Table 1). We have done this in order to analyze in which ways the introduction of a personality functioning scale model brings us closer to the ideal situation voiced by Kiesler so many years ago. Why might this scale prove to be more useful for treatment differentiation than other types of personality scales? Part of the problem with prototype or trait based systems is that as pathology increases, more and more features across traits or categories become present and pathology covers all major domains of life (Hopwood et al.

2011). This leaves clinicians confused—sometimes they need to be directive and at other times this strategy leads to patient anger or even drop-out. With a functioning scale the focus changes from content to process; and it is inherent that at low levels, areas of pathology will be more circumscribed in terms of both processes (e.g. empathy) and in terms of affected life areas (e.g. interpersonal life or even more narrowly, in sustaining a satisfactory life with a partner). We believe the LPF scale may have clear implications for at least preliminary strategic issues in working with personality disorders.

Case Analyses of Personality Functioning

In the following section we explain the background for our ratings summarized in Table 1.

The case of Dieter is about a middle-aged gay man diagnosed with depression and avoidant personality disorder (Pos 2014). In terms of his level of functioning, the picture is very mixed. On the one hand, he is still living at home and has never had a romantic relationship. Present work functioning is likewise poor. On the other hand, he has at times been able to function fairly well, as he has been able to get a law degree and hold a job. He is also described as “very smart, articulate, well-educated and read, and motivated” by the author. In terms of personality, the dominating pattern is one of a sense of inferiority (2) and difficulties in establishing and achieving personal goals (3). His level of empathy (1) seems relatively intact, yet capacity for enduring connection is significantly impaired (3).

The case of Angelo is about a 38 year-old man suffering from the effects of Narcissistic personality disorder, various pathological traits and psychogenic urinary incontinence (Dimaggio et al. 2014). His GAF score is 45 indicating major problems in several life areas such as work and relationships. The authors provide many clear examples of poor metacognition (e.g. scarcely recognizing emotion, limited differentiation) placing him consistently on level 3 of the personality functioning scale.

The case of Mr. A is about a 54 year-old man also diagnosed with Narcissistic personality disorder, bipolar disorder and alcohol abuse (Links and Prakash 2014). He completed university and has had a career in the military lasting 15 years. He is described as being “grandiose, assertive and at times arrogant”. In terms of personality functioning, we again consistently rated him as belonging to level 2 and found the descriptions there to fit concisely with case material presented by the authors (e.g. his lacking ability to consider his wife’s perspective).

The third case of Narcissistic personality disorder is Mark who is a 40 year-old salesman in charge of a

Table 1 Personality functioning and relatedness to psychotherapeutic techniques and strategies

CASE	Diagnosis	Personality dysfunction				Psychotherapeutic techniques and strategies
		Agency		Communion		
		Identity	Self-directedness	Empathy	Intimacy	
Dieter	Avoidant personality disorder	Sense of inferiority (2)	Difficulty in establishing or achieving personal goals (3)	Although capable of considering and understanding different perspectives, resists doing so (1)	Some desire to form relationships in community and personal life is present, but capacity for positive and enduring connection is significantly impaired (3)	<i>Model:</i> Emotion-focused Therapy Start with self-split work and finish with unfinished business <i>Attentive to:</i> Therapeutic relationship, case formulation, productive arousal and hot psychoeducation.
Angelo	Narcissistic Personality Disorder Somatoform disorder	A weak sense of autonomy/agency; experience of a lack of identity, or emptiness (3)	Significantly compromised ability to reflect upon and understand own mental processes (3)	Generally unable to consider alternative perspectives; highly threatened by differences of opinion or alternative viewpoints (3)	Little mutuality: others are conceptualized primarily in terms of how they affect the self (negatively or positively); cooperative efforts are often disrupted due to the perception of slights from others (3)	<i>Model:</i> Metacognitive Interpersonal Therapy Start with shared formulation and then proceed to change promoting <i>Attentive to:</i> Therapeutic relationship, narrative style, differentiation access to healthy self and behavioral tasks
Mr. A	Narcissistic Personality Disorder Bipolar affective disorder Alcohol abuse	Emotional regulation depends on positive external appraisal. Threats to self-esteem may engender strong emotions such as rage or shame (2)	Goals are more often a means of gaining external approval than self-generated, and thus may lack coherence and/or stability (2)	Excessively self-referential; significantly compromised ability to appreciate and understand others' experiences and to consider alternative perspectives (2)	Tends not to view relationships in reciprocal terms, and cooperates predominantly for personal gain (2)	<i>Model:</i> Psychodynamic Therapy Assess vulnerable characteristics, offer gratification and help to increase self-cohesion <i>Attentive to:</i> Suicidal risks and masculinity norms.
Mark	Narcissistic Personality Disorder Major Depression	Relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions and mental distress are experienced (1)	May have an unrealistic or socially inappropriate set of personal standards, limiting some aspects of fulfillment (1)	Excessively self-referential; significantly compromised ability to appreciate and understand others' experiences and to consider alternative perspectives. (2)	Capacity and desire to form intimate and reciprocal relationships, but may be inhibited in meaningful expression and sometimes constrained if intense emotions or conflicts arise. (1)	<i>Model:</i> Motive-oriented therapy Use Plan analysis to establish constructive relationship. <i>Attentive to:</i> Balance between serving patient's needs and cautious confrontation with core issues.

Table 1 continued

CASE	Diagnosis	Personality dysfunction				Psychotherapeutic techniques and strategies
		Agency		Communion		
		Identity	Self-directedness	Empathy	Intimacy	
Eva	Schizotypal & Avoidant Personality Disorder Borderline traits Substance dependence	Fragile self-esteem is easily influenced by events, and self-image lacks coherence. Self-appraisal is un-nuanced: self-loathing, self-aggrandizing, or an illogical, unrealistic combination (3)	Significantly compromised ability to reflect upon and understand own mental processes (3)	Generally unable to consider alternative perspectives; highly threatened by differences of opinion or alternative viewpoints (3)	Some desire to form relationships in community and personal life is present, but capacity for positive and enduring connection is significantly impaired (3)	<i>Model:</i> Mentalization-based treatment Stimulate mentalizing <i>Attentive to:</i> Therapeutic relationship and prementalistic modes. Focus on here and now.
No case	Borderline Personality Disorder	A weak sense of autonomy/agency; experience of a lack of identity, or emptiness (3)	Difficulty establishing and/or achieving personal goals. - Internal standards for behavior are unclear or contradictory. Life is experienced as meaningless or dangerous (3)	Confusion or unawareness of impact of own actions on others; often bewildered about peoples' thoughts and actions, with destructive motivations frequently misattributed to others (3)	Little mutuality: others are conceptualized primarily in terms of how they affect the self (negatively or positively); cooperative efforts are often disrupted due to the perception of slights from others (3)	<i>Model:</i> Dialectical Behavioral Therapy and Acceptance and Commitment therapy Increase values-consistent behavior <i>Attentive to:</i> Value clarification, connecting DBT skills with value and impact of trauma on values

Level of personality functioning scale 0–4 (0 highest functioning, 4 lowest)

department at a large insurance company (Kramer et al. 2014). He is described as “very successful in his work”. He has been married for approximately 10 years and has a daughter who is five years old. On the personality functioning scale, we rated him consistently on level 1, except for empathy where the in-session transcript provides several examples of signs of more pathology being present (level 2). Generally, we consider Mark’s problems with communion to be greater than his problems with agency.

The case of Eva is a about a 28-year old woman with a disorganized attachment pattern and schizotypal personality disorder as well as avoidant PD, substance abuse and a sub threshold level of BPD (Morken et al. 2014). She has a long history of psychiatric treatment. At admission, GAF score was 50 and GSI 1.50. The case material presented is from her second year of treatment, and our scores are primarily based on this period. From the transcripts, it is clear that Eva is mostly functioning in prementalistic modes such as pretend mode and psychic equivalence and we considered placing Eva on level 4 in terms of functioning. Instead, we rated three across all areas of functioning. Admittedly, we find this distinction at the highest level somewhat difficult. However, some positive qualities

are present in the case: With the support of a social counselor, Eva is able to attend high school, “she came to her sessions with a wish to figure things out” and “sometimes Eva did open up in the group, contributing with interpersonal events or commenting on other group members”.

Lastly, Cameron and colleagues (2014) present the serious problem of BPD patients who drop-out of treatment. They link dropout to evidence suggesting that BPD patients may be less willing to experience distress in order to pursue goal-directed behavior. To the extent that this is a fairly consistent issue, it is a problem at level 3 and especially pertains to the area of self-directedness. As the problem is framed by the authors, it is also clear that many patients who dropout have difficulties with a weak and inconsistent sense of themselves (identity) and often experience that cooperative efforts are disrupted (intimacy). Similarly to the case of Eva, many of the problems described are clearly also relevant at level 4.

We fully acknowledge that our ratings are based on next to little experience with the scale and limited access to the cases described. Clearly, our approach to test the utility of LPF scale in the 5 case vignettes has its strong limitations

as neither the agency nor the communion was exactly in focus while the authors made their case descriptions. With that said, we do believe that viewing the cases and the strategic issues through the personality functioning scale is helpful and may offer some perspectives for future studies. First, it is clear that the dimensional nature of personality disorder seems to be captured and adds incrementally to categorical diagnoses. NPD is present in three cases. From a categorical perspective each case would be considered highly complex due to the presence of several comorbid diagnoses. Using the personality functioning scale, it becomes evident that the cases differ in both degree and kind.

Some important questions may be raised in regards to the psychotherapeutic utility of LPFS:

Firstly, are the approaches connected to the level of personality functioning? On the simplest level the approaches could vary in terms of their time frame with less severely disturbed patients receiving shorter treatments. This is not consistently the case. The longest treatment is EFT which is 4.5 years although the average dysfunctioning is 2.25. The most disturbed patients at level 3 are treated for 2 years (MIT and MBT). The treatment length of an integrated DBT/ACT model is not discussed but probably would involve a similar time frame. The least impaired (1.25) patient is Mark who is offered a seven-week treatment followed by further treatment of unknown duration. Slightly more impaired, Mr. A. (2.0) is offered a six-week outpatient treatment followed by individual therapy, again of unknown duration. Secondly, is the level of functioning connected to treatment intensity? There is some tendency for this with MBT and DBT typically consisting of weekly therapy, both group and individual. However, MIT is an individually based treatment, whereas Mr. A. receives both group (short-term) and individual therapy.

Probably there is no simple association between the structural properties of the treatments and the level of personality functioning. Instead, we would like to suggest that differences in strategies to some extent can be understood with reference to differences in severity of personality functioning.

Working with Differentiation and Integration

In cases of severe personality disorder there is a high level of pathology across both agency and communion. As emotional dysregulation increases, so does interpersonal problems leaving patients with no platform to start from because both self and relationships with others are experienced as painful or empty (Simonsen and Simonsen 2009). The therapist working with more severe personality disorder needs to have a strategy to counteract this

problem, regardless of whether patients belong to borderline, skizotypal or narcissistic categories. A key component in severe personality disorder is lack of *differentiation*. Differentiation of self is a term which is often used within systems- and developmental theory. Although the emphasis and boundaries of the differentiation term can vary across theorists, the term broadly implies that the personality is under-developed or lacks complexity in the sense that sub-systems capable of more specialized performance have not been formed (Siegel 2001; Kozhevnikov 2007). Within the Bowen theory, intrapsychic differentiation especially refers to the ability to differentiate and willfully shift between thoughts and emotions, while interpersonal differentiation has to do with having flexible boundaries with other people (Skowron and Friedlander, 1998). Level of intrapsychic differentiation is closely linked to the agency domain in the LPF scale, while interpersonal differentiation is associated with the communion domain. In the three most severe cases in this issue, there is clear evidence of problems with differentiation. Cameron et al. (2014) make a link between problems with motivation and dropout from treatment. Such patients make drastic decisions about treatment often based on emotions and are often bewildered and confused about what they are doing and where they are going. By helping patients to differentiate their own values from those of others and specifying reasons for their importance, this approach helps patients balance the relationship between thought and emotion and with maintaining the self in relation to other. In the case of Eva described by Morken et al. (2014), the patient is not able to accept the depth of her problems and consistently tries to distance herself from the therapist and fellow patients. Morken et al. (2014) points to mentalizing of the relationship as a way to reach the patient. Being attentive to pre-mentalistic modes such as psychic equivalence and pretend mode, the therapist is constantly monitoring the balance between thought and emotion, inner and outer reality. Finally, in the case by Dimaggio et al. (2014), a narcissistic patient with psychogenic urinary problems distances himself by being critical of the therapist and by intellectualizing. Dimaggio et al. (2014) points to self-disclosing, evocation of memories and emotional, bodily awareness as important therapeutic interventions. Luyten et al. (2012) have pointed out how patients with functional somatic disorders are especially deficient in regards to embodied mentalization or as pointed out by Dimaggio et al. (2014), have problems with connecting interpersonal situations with bodily fluctuations and emotions. Barrett et al. (2001) have provided some nice data on how heightening of negative emotional differentiation is associated with enhanced emotional regulation. How to help some patients achieve this is clearly articulated in the case of Angelo described by Dimaggio et al. (2014).

As pointed out by Critchfield and Benjamin (2006), a therapist working with personality disorder has to have a high tolerance for frustrations in the therapeutic relationship. But what can therapists do to change the game in the long run? Critchfield and Benjamin propose being fairly active in the relationship. In the case of severe personality disorder, the cases we have reviewed suggest that this activity is in the form of mentalizing the relationship (Bateman and Fonagy 2006), exploring patient values and stimulating autobiographical memory (Dimaggio et al. 2012). Why might these strategies be so important at high levels of pathology? We would like to suggest that what these three strategies have in common is that they all help the therapist to continue to view and treat patients as intentional and multilayered persons. This strategy in turn helps patients to stimulate distance or differentiation from pathological self states. Once patients have reached sufficient differentiation, pathology becomes less painful and can be managed, probably using some of the more specified strategies described in less severe cases.

All skillful therapists have a clear and consistent strategy and are able to stand firm even under heavy fire. As previously noted, severe personality pathology covers all or most domains of functioning; however, different methods such as MIT, MBT or DBT/ACT have different foci which may be of strategic value for promoting differentiation within very specific areas of pathology, e.g. focusing on autobiographical memory when dealing with problems of over generalized memory and intellectualizing.

In the cases of Dieter (Pos 2014), Mr. A.'s (Links and Prakash 2014) and Mark (Kramer et al. 2014) pathology is generally less severe and in each case certain domains of personality has some attractive features. Dieter has "social grace" and some capacity "to name his feeling" and Mr. A. "was motivated to examine the reasons for his depression". Generally, there is in all three patients a higher level of differentiation—there is a shared platform from which patient and therapist can work from. The problem is instead with integration. Siegel (2001) discusses how one form of impaired integration has to do with unresolved grief and trauma. In some situations—especially with children—people with unresolved grief or trauma enter altered "low-road" states where the mind loses connection to prefrontal structures. In each of the three cases presented here the personality dysfunction is not global but instead involves such "trigger situations" that pull patients into altered states. In all three of these cases, the authors create very clear links between such situations and the patient's personal narrative. It may be that by helping the patient see a connection between his past relationship (with father) with present relationship (with son or daughter) it becomes possible to get back on the "high-road" or at least become more mindful of those situations. It is noteworthy that each

of the authors describes fairly specific techniques aimed at more circumscribed problems of personality. A main problem in the two cases of narcissism is empathic dysfunction. This fits nicely with neurobiological data suggesting that gray matter abnormality is implicated in impaired empathy in narcissistic patients (Schulze et al. 2013). In the case discussed by Kramer et al. (2014) Mark "gets extremely angry and feels overwhelmed by his emotions" and also has a tendency to externalize responsibility without much immediate consideration of the effects on other people. In seven sessions of pretreatment a therapist working with plan analysis and very specific interventions based on complementarities is able to *integrate* behaviors (e.g. taking responsibility) and display of genuine sadness, at odds with his regular pattern. Mr. A., discussed by Links and Prakash (2014) also loses his temper and becomes dysregulated, especially when faced with his son and his wife. Within a psychodynamic framework, the authors then discuss how vulnerable narcissist can be helped by working through core issues and moving across the triangle of insight. Finally, Alberta Pos in the case of Dieter shows how chair-work is a method for integrating split-off self-representations within a trusting therapeutic relationship. What seems to be integrated in each of these cases is apart from the personal narrative concrete corrective experiences that in time are likely to bring the patients to a higher level of personality functioning. For example, the conscious effort of Mark's therapist enables him to meet Mark with compassion instead of anger which in turn creates a possibility for Mark to develop his empathy with others. The systematic chair works with careful consideration of activated emotions schemes helps Dieter to confront aspects of his personality and family history which he has not been able to deal with himself. The integration of more accepting and adaptive aspects surely will help Dieter to a higher level of agency (self-direction). It may be that when therapists are faced with the challenges of lower levels of personality pathology, it is not sufficient to have an overall strategy such as enhancing mentalizing. As problems become more circumscribed, strategies for what is therapeutic becomes more specified and in a sense more specialized. The therapist needs to behave in complementary manner in regards to very specific motives and needs to pay special attention not to reinforce particular secondary emotional schemes.

Final Thoughts and Considerations

First, a common important strategy seems to be the importance of addressing the underlying causes of overt behaviors. Links and Prakash (2014) look for the underlying shame and vulnerability behind narcissism. Similarly,

Pos sees the “core critic” behind the reduced self-direction and attachment avoidance. Kramer looks for the acceptable motives and Dimaggio addresses problems of underlying lack of vitality. Related to this is the therapist’s ability to tease out more adaptive aspects of patient personality. Cameron and colleagues, for instance, work with valuing from both top-down perspectives—asking patients about values—but also from the bottom-up—extracting values from concrete behaviors. Morken et al. (2014) continually ascribe or assume that the patient has in her some capacity for experiencing, naming and sharing mental states.

Secondly, all papers have some focus on the importance of the relationship between therapist and patient and especially stress the importance of validation and empathy. It is hard not to agree on a basic level with this assertion, but there seems to be a lack of precision as to what should count as being empathic. Pos suggests that empathy is more than expressed understanding and includes an ability to help patients regulate emotions. Kramer et al. (2014) suggests that therapists use plan analysis to ensure that empathy is not provided at lower level dysfunctional motives. Perhaps it is helpful to use Heinz Kohut’s distinction between experience-distant and experience-near empathy as a way of separating empathic responses (Kohut 1990). For instance, in discussing diagnosis with the patient, Morken et al. (2014) have the following transcript: P: “Yes, and I get suspicious because I don’t see myself as that much of an attractive human being and don’t expect others to either.” T: “Mhmm, but that is pretty harsh things to think about oneself”. P: “ugh”. T: “But they are not truths are they” P: “Did I say anything that sounded like me presenting it as truths?”

As we see it, it is not that the therapist is not empathic and trying to regulate emotions, rather the problem is that empathy is expressed from a position that in Kohutian terms is too distant from the patient’s experience at that moment. When this happens trying to be empathic is probably experienced as invalidating which leads to further anger.

Thirdly, we will question the way autobiographical memory is sometimes understood and used in treatment of patients. This was particularly evident in the emotion focused method described by Alberta Pos. Spinhoven et al. (2009) and Dimaggio et al. (2007) have shown that autobiographical memory of patients with Cluster C pathology manifests reduced specificity or overgenerality. This seems fairly clear in the case of Dieter who in the beginning of therapy tends to be protective of his family/father but after the father’s death, Dieter becomes highly critical of the father, who is portrayed as somewhat of a monster, with whom the patient has “unfinished business”. The patient is led by the therapist to hold the father “accountable” by expressing anger and disappointment. We greatly appreciate

the multilayered approach to personality when doing chair-work with emotion focused therapy but find that nuances and ownership of perspective is somewhat lacking in regards to how autobiographical memories are treated within this approach. Autobiographical memory is more than what, when and where (episodic memory). It is also about taking ownership for one’s particular perspective of one’s life and includes the experience of self in the situation. If we look at what parents of children with more advanced autobiographical memory do, the important component seems to be asking open-ended questions, being curious and sharing perspectives through reminiscing (for an excellent review see Fivush 2011). The development of autobiographical memory has important implications for the development of self-definition, self in relation to other schemas and for self regulation. From our perspective talking about “unfinished business” is a way of downplaying the importance of slowly developing the autobiographical self and instead emphasizing the importance of catharsis.

Finally, we really liked the idea of valuing and motivational work expressed by Cameron et al. (2014) but we also found certain aspects quite underexplored. The authors themselves point to the problems of the lack of “guide-post” beyond “life worth living” and what one is “passionate about” in DBT. We are not convinced that we get that much further in some of the values specified in the article. We found two values namely self-respect and connectedness. It is hard to imagine that most people would not see these values as important. To get further with creating guidelines for values there are least two important questions that need to be figured out. One problem relates to the fact that many people talk about values in a way that is not really connected to inner life (in a pretend mode). How does one challenge this in a way that enables the person to connect to something that feels real? The other problem which is perhaps related has to do with the level of specificity when talking about values or goals more generally. Is it important to formulate long-term abstract values such as being a nice person or is it the short-term concrete values that matter—doing nice things today? (For a nice example of the importance of the latter see Alden and Trew 2013). We look forward to much more needed work on this important subject of motivational work with patients suffering from personality disorders.

In this commentary we have tried to make a connection between the LPF scale and strategic issues in treatment of personality disorders and briefly argued that the scale has some attractive features in this regard. As reliable methods for assessment of the LPF scale are developed, research should evidently progress along more experimental lines. The scale’s ability to differentiate patients in need of different levels of care should be investigated, as should opinions about clinical utility and acceptability of both

clinicians and patients. Although the papers presented in this edition in many ways are impressive, we believe Paul E. Meehl's prediction nearly sixty years ago still holds true:

"The lessons would seem to be that we know so little about the process of helping that the only proper attitude is one of maximum experimentalism. The state of theory and its relation to technique is obviously chaotic whatever our pretensions (Meehl 1955, pp 374–375)".

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